Welcome to Pet Medical Center

CLIENT REGISTRATION

Date: ___/___/___

Owner's Name(s) ____
(if married, please give both names)

Street Address ____

City, State, Zip ____

Phone Numbers: Home phone #______________________ Work phone #__________________________

Cell phone #________________________ Spouse cell phone # _____________________

E-mail address ____

Driver's license number and state ____

How were you referred to us? (if an existing client referred you, please include their first and last name so that we can thank them!) ____

PATIENT INFORMATION

	PET # 1	PET # 2	PET # 3	PET # 4
Name	________________	________________	________________	________________
Breed	________________	________________	________________	________________
Date of Birth	________________	________________	________________	________________
Color	________________	________________	________________	________________
Sex: F, M, Spayed/Neutered?	________________	________________	________________	________________

I understand that payment for services rendered is due upon receipt. Payment options include credit card, debit card, cash, Care Credit, or Scratch Pay.

I understand that Pet Medical Center requires an annual exam of my pet(s) for continuing health care, to include refill of medications.

I understand that rude or abusive behavior towards the staff or other clients of Pet Medical Center will not be tolerated and will lead to immediate dismissal as a client.

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Signature